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Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA Central California HCS, CA - 570

VISN 21

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 3322

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1014

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **3322** (point-in-time estimate of homeless veterans in service area) **X 36%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 85%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1014** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1432	38
Transitional Housing Beds	0	150
Permanent Housing Beds	217	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Work with Fresno Madera Continuum of Care and other non-profits in providing information and explanations regarding the VA Grant and Per Diem Program.
Help with Transportation	Work with the Fresno Madera Continuum of Care and other nonprofits in providing information and explanations regarding Grant and Per Diem grant money for vans. Will also explore potential support from Veterans Service Organizations in addressing transportation needs.
Help with finding a job or getting employment	Outreach and future Stand Down participants/resources will reflect emphasis on employment.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 26 Non-VA staff Participants: 69%
Homeless/Formerly Homeless: 8%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Drop-in center or day program	2.05	4%	2.77	10
2	Halfway house or transitional living facility	2.08	57%	2.76	8
3	Long-term, permanent housing	2.08	17%	2.25	1
4	Legal assistance	2.19	0%	2.61	4
5	Family counseling	2.24	0%	2.85	12
6	Child care	2.3	0%	2.39	3
7	Help managing money	2.32	4%	2.71	7
8	Job training	2.32	22%	2.88	14
9	Education	2.43	4%	2.88	13
10	Welfare payments	2.45	0%	2.97	16
11	Help with finding a job or getting employment	2.45	4%	3.00	17
12	Emergency (immediate) shelter	2.52	48%	3.04	20
13	Dental care	2.52	0%	2.34	2
14	Eye care	2.59	4%	2.65	5
15	Discharge upgrade	2.65	0%	2.90	15
16	Women's health care	2.68	0%	3.09	21
17	Guardianship (financial)	2.71	0%	2.76	9
18	Help with medication	2.73	0%	3.18	24
19	Glasses	2.76	0%	2.67	6
20	Help with transportation	2.76	17%	2.82	11
21	Treatment for dual diagnosis	2.81	4%	3.01	18
22	Help getting needed documents or identification	2.81	0%	3.16	23
23	Services for emotional or psychiatric problems	2.86	0%	3.20	25
24	Treatment for substance abuse	2.91	0%	3.30	28
25	Personal hygiene (shower, haircut, etc.)	2.95	0%	3.21	26
26	Food	2.95	0%	3.56	35
27	Clothing	2.95	0%	3.40	31
28	VA disability/pension	3	0%	3.33	29
29	SSI/SSD process	3	0%	3.02	19
30	Detoxification from substances	3.09	4%	3.11	22
31	TB treatment	3.14	0%	3.45	33
32	Medical services	3.23	0%	3.55	34
33	TB testing	3.23	0%	3.58	36
34	Spiritual	3.23	4%	3.30	27
35	AIDS/HIV testing/counseling	3.35	0%	3.38	30
36	Hepatitis C testing	3.45	0%	3.41	32

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	2.83	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.33	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	2.65	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.25	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	2.83	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.39	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.28	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.71	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.71	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.67	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.65	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.59	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.47	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.65	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.41	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.35	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.41	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.29	1.84

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CHALENG 2004 Survey: VA Northern California HCS - 612 (Martinez, Oakland and Sacramento)

VISN 21

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 5000

2. Point-in-time estimate of Veterans who are Chronically Homeless: 2211

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **5000** (point-in-time estimate of homeless veterans in service area) **X 52%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 85%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 2211** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	430	30
Transitional Housing Beds	200	30
Permanent Housing Beds	0	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 20

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Work with local counties and community resource to develop and increase in transitional living facilities/half-way houses.
Drop-in Center or Day Program	Explore community possibilities for creation of a day treatment facility and recreational facilities to engage vets who are unable to work or participate in other programming.
Clothing	No change

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 37 Non-VA staff Participants: 80% Homeless/Formerly Homeless: 70%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	1.86	31%	2.34	2
2	Child care	2.09	0%	2.39	3
3	Long-term, permanent housing	2.11	39%	2.25	1
4	Welfare payments	2.12	0%	2.97	16
5	Spiritual	2.24	3%	3.30	27
6	Guardianship (financial)	2.3	0%	2.76	9
7	Legal assistance	2.32	6%	2.61	4
8	Family counseling	2.34	3%	2.85	12
9	SSI/SSD process	2.35	0%	3.02	19
10	Drop-in center or day program	2.44	13%	2.77	10
11	Help managing money	2.45	6%	2.71	7
12	Discharge upgrade	2.5	0%	2.90	15
13	Eye care	2.53	3%	2.65	5
14	Glasses	2.6	3%	2.67	6
15	VA disability/pension	2.63	0%	3.33	29
16	Treatment for dual diagnosis	2.66	3%	3.01	18
17	Detoxification from substances	2.79	0%	3.11	22
18	Emergency (immediate) shelter	2.8	13%	3.04	20
19	Education	2.8	3%	2.88	13
20	Services for emotional or psychiatric problems	2.86	3%	3.20	25
21	Women's health care	2.88	0%	3.09	21
22	Help getting needed documents or identification	2.94	0%	3.16	23
23	Help with transportation	2.94	0%	2.82	11
24	Clothing	2.97	0%	3.40	31
25	AIDS/HIV testing/counseling	2.97	0%	3.38	30
26	Hepatitis C testing	3	0%	3.41	32
27	Job training	3	13%	2.88	14
28	Halfway house or transitional living facility	3.09	31%	2.76	8
29	Help with medication	3.14	0%	3.18	24
30	Help with finding a job or getting employment	3.14	9%	3.00	17
31	Treatment for substance abuse	3.18	3%	3.30	28
32	Medical services	3.2	6%	3.55	34
33	Personal hygiene (shower, haircut, etc.)	3.34	0%	3.21	26
34	TB treatment	3.47	0%	3.45	33
35	Food	3.53	3%	3.56	35
36	TB testing	3.8	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	2.97	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.81	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.15	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.51	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.5	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.5	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.29	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.49	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.67	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.48	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.94	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.23	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.16	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.9	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.37	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.55	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.03	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.9	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.94	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.21	1.84

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CHALENG 2004 Survey: VA Palo Alto HCS (VAMC Livermore - 640A4 and VAMC Palo Alto - 640), Menlo Park, CA

VISN 21

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 3000

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1083

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **3000** (point-in-time estimate of homeless veterans in service area) **X 41%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 87%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1083** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	350	200
Transitional Housing Beds	356	300
Permanent Housing Beds	200	400

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Continue to seek community funding.
Long-term, permanent housing	Work with community to develop and fund housing.
Help with Transportation	Encouraging VA Grant and Per Diem sites to allocate funds for transportation.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 17 Non-VA staff Participants: 88%
Homeless/Formerly Homeless: 6%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.41	31%	2.34	2
2	Long-term, permanent housing	2.47	19%	2.25	1
3	Glasses	2.5	0%	2.67	6
4	Eye care	2.59	6%	2.65	5
5	Guardianship (financial)	2.59	0%	2.76	9
6	Help managing money	2.71	13%	2.71	7
7	Legal assistance	2.71	6%	2.61	4
8	Child care	2.76	0%	2.39	3
9	Help with transportation	2.88	6%	2.82	11
10	Drop-in center or day program	2.94	0%	2.77	10
11	Emergency (immediate) shelter	3	31%	3.04	20
12	Welfare payments	3.13	6%	2.97	16
13	Job training	3.13	19%	2.88	14
14	Detoxification from substances	3.18	0%	3.11	22
15	Discharge upgrade	3.24	6%	2.90	15
16	SSI/SSD process	3.29	6%	3.02	19
17	Help getting needed documents or identification	3.35	0%	3.16	23
18	Treatment for dual diagnosis	3.41	0%	3.01	18
19	VA disability/pension	3.41	6%	3.33	29
20	Education	3.41	0%	2.88	13
21	Services for emotional or psychiatric problems	3.47	6%	3.20	25
22	Family counseling	3.47	0%	2.85	12
23	Women's health care	3.47	0%	3.09	21
24	Help with medication	3.47	0%	3.18	24
25	Help with finding a job or getting employment	3.47	25%	3.00	17
26	Halfway house or transitional living facility	3.53	13%	2.76	8
27	Hepatitis C testing	3.56	0%	3.41	32
28	Treatment for substance abuse	3.59	0%	3.30	28
29	Personal hygiene (shower, haircut, etc.)	3.65	0%	3.21	26
30	Clothing	3.65	0%	3.40	31
31	AIDS/HIV testing/counseling	3.71	0%	3.38	30
32	Spiritual	3.75	0%	3.30	27
33	Food	3.88	0%	3.56	35
34	Medical services	3.88	0%	3.55	34
35	TB treatment	3.88	0%	3.45	33
36	TB testing	4.18	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.53	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.47	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.41	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.94	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.29	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.69	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.69	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.35	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	3.71	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.53	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.47	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.35	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.29	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3.41	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.88	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.88	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.41	1.84

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CHALENG 2004 Survey: VA Sierra Nevada HCS, NV - 654

VISN 21

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 220

2. Point-in-time estimate of Veterans who are Chronically Homeless: 39

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **220** (point-in-time estimate of homeless veterans in service area) **X 21%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 84%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 39** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	187	130
Transitional Housing Beds	665	28
Permanent Housing Beds	477	78

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 12

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Increase housing options and adopt housing first models. Priority is to increase permanent supportive housing options for chronically homeless individuals. Reno Area Alliance for the Homeless rating and ranking process for Continuum of Care funding will award maximum bonus points to Continuum projects that address its priority areas as permanent supportive housing for chronic homeless individuals. Includes new 3-year permanent supportive housing project to assist homeless individuals with mental illness. Will provide for scattered site housing with supportive services.
Immediate shelter	Site has been selected, architectural renderings completed and ground broken for new emergency shelter for men, women with children. Occupation of shelter scheduled for June 2005. Will also include office space for service providers, day resource center and triage center. Triage center will serve as alternative for individuals with a mental illness or substance abuse issue who would otherwise end up in an emergency room or jail.
Transitional living facility	Increase transitional housing/halfway houses by continuing to work with agencies that wish to apply for Per Diem funding, if another round is announced. Seek informal agreements with providers.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 15 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	1.69	13%	2.39	3
2	Long-term, permanent housing	1.8	53%	2.25	1
3	Emergency (immediate) shelter	1.87	40%	3.04	20
4	Halfway house or transitional living facility	2	40%	2.76	8
5	Dental care	2	0%	2.34	2
6	Treatment for dual diagnosis	2.13	0%	3.01	18
7	Services for emotional or psychiatric problems	2.2	0%	3.20	25
8	Eye care	2.27	0%	2.65	5
9	Glasses	2.27	0%	2.67	6
10	Drop-in center or day program	2.31	7%	2.77	10
11	Detoxification from substances	2.33	7%	3.11	22
12	Discharge upgrade	2.38	0%	2.90	15
13	Family counseling	2.43	0%	2.85	12
14	Help getting needed documents or identification	2.53	0%	3.16	23
15	Guardianship (financial)	2.54	0%	2.76	9
16	Legal assistance	2.54	0%	2.61	4
17	Help with transportation	2.57	0%	2.82	11
18	SSI/SSD process	2.62	0%	3.02	19
19	Help managing money	2.62	7%	2.71	7
20	Treatment for substance abuse	2.67	0%	3.30	28
21	Education	2.77	0%	2.88	13
22	Personal hygiene (shower, haircut, etc.)	2.8	0%	3.21	26
23	Women's health care	2.86	0%	3.09	21
24	Job training	2.87	7%	2.88	14
25	Welfare payments	2.92	0%	2.97	16
26	Help with finding a job or getting employment	3	7%	3.00	17
27	Help with medication	3.07	0%	3.18	24
28	Hepatitis C testing	3.08	0%	3.41	32
29	VA disability/pension	3.14	0%	3.33	29
30	Clothing	3.2	7%	3.40	31
31	Food	3.27	0%	3.56	35
32	AIDS/HIV testing/counseling	3.38	0%	3.38	30
33	TB testing	3.43	0%	3.58	36
34	TB treatment	3.64	0%	3.45	33
35	Medical services	3.67	13%	3.55	34
36	Spiritual	3.79	7%	3.30	27

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.86	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.14	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.69	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.29	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.86	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.64	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.62	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.5	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.62	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.57	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.08	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.43	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.23	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.45	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.46	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.36	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.31	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.42	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.85	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAM&ROC Honolulu, HI - 459

VISN 21

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 800

2. Point-in-time estimate of Veterans who are Chronically Homeless: 134

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **800** (point-in-time estimate of homeless veterans in service area) **X 24%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 70%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 134** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	250	50
Transitional Housing Beds	150	50
Permanent Housing Beds	110	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Drop-in Center or Day Program	Work with Waianae Community Outreach to develop program.
Dental Care	Work with VA Dental Services on Homeless Dental Initiative.
Long-term, permanent housing	Work for VA Central Office NOFA

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 11 Non-VA staff Participants: 30%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2	0%	2.39	3
2	Dental care	2.45	13%	2.34	2
3	Drop-in center or day program	2.64	56%	2.77	10
4	Glasses	2.64	0%	2.67	6
5	Legal assistance	2.7	25%	2.61	4
6	Long-term, permanent housing	2.73	22%	2.25	1
7	Education	3	0%	2.88	13
8	Job training	3.1	0%	2.88	14
9	Personal hygiene (shower, haircut, etc.)	3.18	0%	3.21	26
10	Eye care	3.18	0%	2.65	5
11	Welfare payments	3.27	0%	2.97	16
12	Guardianship (financial)	3.3	13%	2.76	9
13	Discharge upgrade	3.3	0%	2.90	15
14	Spiritual	3.3	0%	3.30	27
15	SSI/SSD process	3.4	0%	3.02	19
16	Halfway house or transitional living facility	3.55	38%	2.76	8
17	Family counseling	3.73	0%	2.85	12
18	Help with finding a job or getting employment	3.8	0%	3.00	17
19	Help with transportation	3.8	0%	2.82	11
20	Food	3.82	0%	3.56	35
21	Clothing	3.91	0%	3.40	31
22	Detoxification from substances	3.91	0%	3.11	22
23	Emergency (immediate) shelter	4	38%	3.04	20
24	Help getting needed documents or identification	4	0%	3.16	23
25	Help managing money	4.1	0%	2.71	7
26	AIDS/HIV testing/counseling	4.27	0%	3.38	30
27	Services for emotional or psychiatric problems	4.45	0%	3.20	25
28	Treatment for dual diagnosis	4.45	0%	3.01	18
29	VA disability/pension	4.45	0%	3.33	29
30	Help with medication	4.55	0%	3.18	24
31	TB testing	4.64	0%	3.58	36
32	TB treatment	4.64	0%	3.45	33
33	Hepatitis C testing	4.64	0%	3.41	32
34	Treatment for substance abuse	4.73	13%	3.30	28
35	Medical services	4.73	0%	3.55	34
36	Women's health care	4.73	0%	3.09	21

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.38	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.38	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.5	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.88	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.57	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.25	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	3.5	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	3.5	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.5	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.75	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	3.25	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	3	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.75	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.5	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC San Francisco, CA - 662

VISN 21

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 4000

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1368

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **4000** (point-in-time estimate of homeless veterans in service area) **X 40%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 85%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1368** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	600	100
Transitional Housing Beds	90	75
Permanent Housing Beds	215	185

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	<no text>
Treatment for Dual Diagnosis	<no text>
Drop-in Center or Day Program	<no text>

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 32 Non-VA staff Participants: 73% Homeless/Formerly Homeless: 22%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.78	45%	2.25	1
2	Dental care	2.13	7%	2.34	2
3	Child care	2.16	0%	2.39	3
4	Family counseling	2.41	3%	2.85	12
5	Glasses	2.45	0%	2.67	6
6	Legal assistance	2.55	3%	2.61	4
7	Halfway house or transitional living facility	2.56	10%	2.76	8
8	Eye care	2.58	7%	2.65	5
9	Treatment for dual diagnosis	2.61	10%	3.01	18
10	Drop-in center or day program	2.63	0%	2.77	10
11	Emergency (immediate) shelter	2.69	17%	3.04	20
12	Guardianship (financial)	2.69	3%	2.76	9
13	Services for emotional or psychiatric problems	2.72	3%	3.20	25
14	Detoxification from substances	2.75	7%	3.11	22
15	Discharge upgrade	2.77	0%	2.90	15
16	Treatment for substance abuse	2.81	17%	3.30	28
17	Education	2.81	3%	2.88	13
18	Help managing money	2.94	0%	2.71	7
19	SSI/SSD process	2.97	0%	3.02	19
20	Personal hygiene (shower, haircut, etc.)	3.03	0%	3.21	26
21	Welfare payments	3.06	0%	2.97	16
22	Help with transportation	3.06	0%	2.82	11
23	Help with medication	3.09	0%	3.18	24
24	Job training	3.09	17%	2.88	14
25	Help with finding a job or getting employment	3.09	21%	3.00	17
26	Food	3.13	3%	3.56	35
27	Clothing	3.13	0%	3.40	31
28	Women's health care	3.13	0%	3.09	21
29	VA disability/pension	3.13	0%	3.33	29
30	Help getting needed documents or identification	3.22	0%	3.16	23
31	Spiritual	3.24	0%	3.30	27
32	AIDS/HIV testing/counseling	3.38	0%	3.38	30
33	TB treatment	3.53	0%	3.45	33
34	Medical services	3.56	7%	3.55	34
35	TB testing	3.59	0%	3.58	36
36	Hepatitis C testing	3.59	3%	3.41	32

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.44	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.15	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.37	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.11	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.04	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.7	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.84	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.22	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.42	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.5	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.74	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.58	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.96	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.83	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.43	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.65	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.77	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.95	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.04	1.84